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THE RIGHT TO HEALTH CARE IN THE UNITED STATES: LOCAL ANSWERS TO GLOBAL RESPONSIBILITIES

Marcela X. Berdion*

INTRODUCTION

THE idea that access to health care is an essential right for all people has likely existed in the hearts and minds of medical professionals around the world for many years, but a right to health did not become codified as an international human right until the 20th century, with the help of American leadership. President Franklin D. Roosevelt encouraged the United States to embrace the global recognition of a right to health in his State of the Union address in 1944, while advancing his idea of a second Bill of Rights, including “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health.”¹ Today, every country in the world is now party to at least one of the numerous international treaties and legal documents addressing health-related rights, allowing health care to become a truly international ideal and commitment.² The United States, however, has not followed through with FDR’s vision of providing a right to adequate medical care and good health in this country. Although the federal government has made several attempts at shifting the status of health care in the United States away from its past as a purely private market good towards that of at least a limited right with minimum levels of care, federal efforts have failed to meet international standards by establishing health care as a human right for all people within its borders. Instead, a patchwork of government attempts to address medical care needs have left health care in limbo as the product of a private-public system, which partially subsidizes those whom the government deems worthy to receive the privilege of care in this country, but leaves millions of others who do not qualify without essential access to health care. The current system in the United

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1. President’s Message to Congress on the State of the Union, 12 Pub. Papers 41 (Jan. 11, 1944).

2. World Health Organization, Health and Human Rights, <http://www.who.int/hhr/en/> (last visited Sept. 15, 2007).

States therefore recognizes health care only as a privilege for some, not as a human right for all.

As immigration into the United States continues to rise along with health care costs, the privileged status of health care must be examined as the disadvantaged indigent, ethnic, cultural, racial, linguistic, and legal position of many immigrants continually augments the large number of people who lack insurance and public benefits and thus health care under the current system. In light of these challenges, reforms to both the health care and immigration systems are currently at the forefront of public policy discussions in the federal as well as state arenas. For example, President George W. Bush has proposed massive changes to the medical insurance system in the country as well as to immigration policy that could have great impacts on both citizens' and noncitizens' access to health care.³ Governor Schwarzenegger has also recently proposed extending health care coverage to almost all of California's thirty-six million residents.⁴ If the proposal is passed, California would become the largest state, joining Maine, Massachusetts, and Vermont, to have near-universal health care for its residents.⁵ Additionally, Schwarzenegger's proposal highlights the health care issues present in states with large immigrant populations, as it does not cover all Californian residents. Under the proposal, undocumented children living in homes where the family income is up to 300% above the poverty line would receive Medi-Cal (the state's Medicaid program) benefits; however, undocumented immigrant adults would not receive Medi-Cal assistance, leaving at least one million of California's residents who are undocumented immigrants without Medicaid benefits.⁶ Even though millions of people would remain without health care under the plan, many citizens of California will likely object to even the coverage of undocumented children,⁷ a probable outcome considering the anti-immigration sentiment that has existed in that state, as reflected in the now-defeated Proposition 187 of 1994.⁸ California's proposal demonstrates the myriad of factors that go into making the health care policy decisions that establish whether medical care is a human right or a restricted privilege. Policy decisions that require balanc-

3. See President George W. Bush, Address Before a Joint Session of the Congress on the State of the Union, 43 WEEKLY COMP. PRESS DOC. 57 (Jan. 23, 2007), <http://www.whitehouse.gov/news/releases/2007/01/20070123-2.html>.

4. Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1.

5. *Id.*

6. *Id.*

7. *Id.*

8. See *Illegal Aliens: Public Services, Verification, and Reporting*, Cal. Legis. Serv. Prop. 187 (West 1994) (codified in scattered sections of the CAL. CODE); see also *League of United Latin Am. Citizens v. Wilson*, 131 F.3d 1297, 1300 (9th Cir. 1997). Proposition 187 severely restricted undocumented immigrants from receiving public education, health, and social services. Alexander Vivero Neill, Comment, *Human Rights Don't Stop at the Border: Why Texas Should Provide Preventative Health Care For Undocumented Immigrants*, 4 SCHOLAR 405, 419 (2002).

ing local sentiments and human health, however, often leave immigrants in the United States caught in the struggle and without care.

Immigrants of all legal statuses should have the same human right to health as all other people in the United States and in the world according to international standards, but many may not receive adequate care if the country's policy makers see health care as merely a privilege. Immigrants therefore provide a fitting lens through which the status of health care in the United States may be examined, as they provide an example of a group of perpetually marginalized people who face multiple barriers to accessing health care. Since the true measure of a country's commitment to human rights is best seen by examining the rights of those who are most disenfranchised, the level of health care access provided to immigrants demonstrates the position of health care in the United States along the spectrum of a mere privilege versus a human right. Additionally, the federal government's categorization of immigrants according to legal status for health care benefits and the steady increase in the numbers of people immigrating both legally and illegally makes immigrants an appropriate group to demonstrate the dangerous consequences of considering health care as a privilege when more and more people in the United States are systematically left without medical care due to their legal status and indigence. The United States, as the most powerful and resourceful country in the world, should meet international health care standards as well as honor its commitments to provide a human right to health for all people within its borders, including all immigrants. The health care debate should move away from a dialogue about who should qualify for care and the associated costs toward a discussion on the best way for every person to receive medical attention. Once health care is recognized as a human right among policy makers and individuals in the United States, this discussion can take place and the country can work towards achieving a high level of human health among all people, rather than apportioning who may receive what care and thus failing millions of people's human rights.

The purpose of this Comment is to examine the attitudes towards health care provision in the United States against the backdrop of international human rights health standards and obligations. Part I provides an overview of the status of health as a human right in the international context, as seen through multiple international treaties, and contrasts this paradigm with the one present in the United States, as seen through the framework of Supreme Court decisions, as well as legislative and executive actions, suggesting that health care is a privilege in America. Part II uses the health care rights of immigrants as a lens to examine the level of rights federal policies have bestowed on one of the most disenfranchised groups in the country and discusses the policy barriers immigrants face in physically accessing both emergency and non-emergency health care, as well as the barriers impeding access to meaningful care as prescribed by international standards. Part III proposes small policy changes Texas can

make in order to pave the way for immigrants to receive greater physical and meaningful access to health care while waiting for the federal government to meet the international standards for human health care rights.

I. HEALTH AS AN INTERNATIONAL RIGHT VS. AN AMERICAN PRIVILEGE

A. HEALTH CARE AS A RIGHT INTERNATIONALLY

The right to health is codified in numerous international legal documents, the most important of which include the Universal Declaration of Human Rights ("UDHR")⁹ and the International Covenant on Economic, Social, and Cultural Rights ("ICESCR").¹⁰ The spirit of Roosevelt's second Bill of Rights became enshrined in the UDHR through Eleanor Roosevelt's leadership as the head of the U.N. Human Rights Commission, and together with its implementing Covenants, the so-called International Bill of Rights seeks to protect the international right to health.¹¹ Article 25 of the UDHR prescribes that, "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing, and medical care and necessary social services."¹² The ICESCR, intended to expand upon the meaning of the rights given in the UDHR, provides the most concrete assertion of the right to health and states in Article 12:

(1) The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. (2) The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for: (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child; (b) The improvement of all aspects of environmental and industrial hygiene; (c) The prevention, treatment and control of epidemic, endemic, occupational, and other diseases; (d) The creation of conditions which would assure to *all* medical service and medical attention in the event of sickness.¹³

Other international legal documents recognizing the right to health include Article 24 of the Convention on the Rights of the Child,¹⁴ Article 5 of The International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (ratified by United States with reservations in

9. Universal Declaration of Human Rights, G.A. Res. 217A, at 76, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter UDHR].

10. International Covenant on Economic, Social and Cultural Rights, Dec. 19, 1966, 993 U.N.T.S. 3 (signed by the United States on Oct. 5, 1977) [hereinafter ICESCR].

11. JEAN CARMALT & SARAH ZAIDI, CTR. FOR ECON. AND SOC. RIGHTS, THE RIGHT TO HEALTH IN THE UNITED STATES OF AMERICA: WHAT DOES IT MEAN? 5 (2004), [http://cesr.org/filestore2/download/733/healthreport-finalonthewebsite\(oct.2028\).pdf](http://cesr.org/filestore2/download/733/healthreport-finalonthewebsite(oct.2028).pdf).

12. UDHR, *supra* note 9, at 76.

13. ICESCR, *supra* note 10, art. 12 (emphasis added).

14. Convention on the Rights of the Child, G.A. Res. 44/25, art. 24, U.N. Doc. A/Res/44/25 (Nov. 20, 1989) (signed by the United States on Feb. 16, 1995).

1994),¹⁵ Articles 11.1(f) and 12 of the Convention on the Elimination of All Forms of Discrimination against Women of 1979,¹⁶ and in many regional agreements, including Article 11 of The American Declaration of the Rights and Duties of Man,¹⁷ and the Additional Protocol to the American Convention on Matters of Economic, Social and Cultural Rights.¹⁸ Furthermore, the commitment to health care is a necessary component of the most basic of all rights: the right to life, which has achieved *jus cogens* status in international law and thus must be upheld by every nation.¹⁹ It is also implicated by many of the other rights upheld by the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, privacy, the prohibition against torture, access to information, and the freedoms of association, assembly and movement.²⁰

The United States led the formation of many of the aforementioned treaties and although it is a signatory to the ICESCR, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women, the Senate has never given its consent to ratify those treaties, which are therefore not legally enforceable in the court system as international treaties under United States law.²¹ However, the American signatures on these international documents are politically binding in the eyes of the international community and demonstrate the country's support of the health provisions set forth in those agreements, as shown by President Carter's and President Clinton's approval of the ICESCR.²² Article 18 of the Vienna Convention on the

15. International Convention on the Elimination of All Forms of Racial Discrimination, G.A. Res. 2106 (XX), art. 5 (Dec. 21, 1965) (entry into force in the United States on Nov. 20, 1994) [hereinafter ICEAFRD].

16. Convention on the Elimination of All Forms of Discrimination against Women, G.A. Res. 34/180, art. 11(f), 12, 34 U.N. GAOR, 34th Sess., 107th plen. mtg. annex at 194, U.N. Doc. A/34/46 (Dec. 18, 1979) (signed by the United States on 17 July 1980).

17. American Declaration of the Rights and Duties of Man, adopted by the Ninth International Conference of American States (1948), Art. XI, O.A.S. Res. XXX, *reprinted in* Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L/V/II.82, doc. 6 rev.1 (1992).

18. Organization of American States: Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, O.A.S.T.S. No. 69, 28 I.L.M. 156, 160, (Nov. 14, 1988) [hereinafter Protocol of San Salvador].

19. Alicia Ely Yamin, *Not Just a Tragedy: Access to Medications as a Right under International Law*, 21 B.U. INT'L L.J. 325, 330 (2003). *Jus cogens* is defined under the Vienna Convention on the Law of Treaties as "a norm accepted and recognized by the international community of States as a whole as a norm from which no derogation is permitted and which can be modified only by a subsequent norm of general international law having the same character." Vienna Convention on the Law of Treaties, art. 53, May 23, 1969, 1155 U.N.T.S. 331, 340, 8 I.L.M. 679, 699.

20. U.N. Comm. on Econ., Soc. & Cultural Rights [CESCR], *General Comment No. 14* (2000), *The Right to the Highest Attainable Standard of Health*, ¶ 3, 22d Sess., U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000).

21. See Office of the U.N. High Comm'r for Human Rights, Status of the Ratification of the Principal International Human Rights Treaties as of 09 June 2004, <http://www.unhchr.ch/pdf/report.pdf> [hereinafter Ratification Status]; see also LOUIS HENKIN ET AL., HUMAN RIGHTS 771-74 (1999).

22. See HENKIN, *supra* note 21, at 783-84; see also CARMALT & ZAIDI, *supra* note 11, at 4, 13 (studying whether the United States' health care system meets the requirements of

Law of Treaties prescribes that upon signing a treaty, a nation is "obliged to refrain from acts which would defeat the object and purpose" of the treaty "until it shall have made its intention clear not to become a party to the treaty."²³ It is likely that the intention not to become a party to the ICESCR is not clear to the international community, given the actions of two presidents as late as 1993 asking for Senate consent of the treaty, such that the United States is internationally committed to refrain from passing legislation that would impede the right to health under the ICESCR.²⁴ Additionally, the United States, although not legally bound by treaty law under UDHR due to its status as a United Nations General Assembly declaration, could be bound to it under the principle of customary international law or as an authoritative interpretation of the United Nations Charter, to which the United States is a signatory and is thus bound to under international treaty law.²⁵ The United States is, however, a party to the International Convention on the Elimination of All Forms of Racial Discrimination, which was ratified by the Senate, and is thus legally obligated, under both international and United States law,

to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of . . . (e) Economic, social and cultural rights, in particular: . . . (iv) The right to public health, medical care, social security and social services.²⁶

It also is considered responsible in the eyes of the international community for fulfilling all of the provisions set forth in the treaties to which the United States is a signatory, including the obligations to respect, protect, and fulfill the right to health under ICESCR by facilitating, providing, and promoting this right in "adopt[ing] appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health."²⁷ The United States, however, has not met these international standards and commitments, and although it has signed and legally bound itself to multiple documents hoping to ensure a universal right to health care, the country still views health care largely as a privilege for some, not a human right for all.²⁸

B. HEALTH CARE AS A PRIVILEGE IN THE UNITED STATES

The United States historically has not recognized a universal human right to health, but rather has viewed health care as a privilege for those

the international human rights standards, and concluding that the American system falls short of meeting its international commitments).

23. Vienna Convention on the Law of Treaties, art. 18, May 23, 1969, 1155 U.N.T.S. 331, 8 I.L.M. 679, 686.

24. See generally HENKIN, *supra* note 21, at 783–84.

25. CARMALT & ZAIDI, *supra* note 11, at 4.

26. ICEAFRD, *supra* note 15, at art. 5.

27. See U.N. CESCR, *General Comment No. 14 (2000)*, *supra* note 20, at ¶ 33.

28. See CARMALT & ZAIDI, *supra* note 11, at 13–19.

who can either afford care through the private market or who the government determines are deserving of charity and meet its requirements for free or discounted care. Before the turn of the century, those who could not afford health care through private physicians were treated in charitable hospitals funded entirely through voluntary charitable donations, but by the 1920s, hospitals had become free market facilities funded by patient fees, as they remain today.²⁹ That private system of care leaves poor uninsured patients dependent upon the charity of the government to provide federal programs (such as Medicaid) and financial and structural support to community health centers, free clinics, individual physicians who freely donate their services, and hospitals to provide emergency care.³⁰ Although the United States spends more on health care per person than any other industrialized country—an estimated \$5,267 per person per year, which comprised thirteen percent of United States Gross Domestic Product in 2000—it is the only industrial country in the world that does not provide universal access to medical services.³¹ Presently, the United States is also the only industrialized country in the world that does not recognize the human right to health care in its courts or in federal legislation.³²

1. Recognition of Health Rights in the Supreme Court

The United States Constitution does not explicitly address a right to health care, and the Supreme Court has never interpreted an implicit right to health under the Due Process Clause of the Fourteenth Amendment.³³ Although the Court has determined that the Constitution implicitly confers a right to privacy that includes the right to have an abortion,³⁴ use contraception,³⁵ procreate,³⁶ and maintain bodily integrity,³⁷ it has not recognized a right to health generally. On the contrary, the Supreme Court, in the case of *Maier v. Roe*, stated that “[t]he Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents,” and couched abortion rights as merely protecting a woman’s right to choose whether to terminate a pregnancy, rather than a constitutional right to an abortion as a health right.³⁸ The Court then decided in *Harris v. McRae* that “[a]lthough the liberty protected by the

29. William P. Gunnar, *The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?*, 15 *ANALS HEALTH L.* 151, 173–74 (2006).

30. *Id.* at 174, 179.

31. See CARMALT & ZAIDI, *supra* note 11, at 11–12.

32. *Id.* at 8, 11.

33. Gunnar, *supra* note 29, at 156–58.

34. See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

35. See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

36. See *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).

37. See *Washington v. Harper*, 494 U.S. 210, 221–22 (1990); see also *Winston v. Lee*, 470 U.S. 753, 766–67 (1985).

38. *Maier v. Roe*, 432 U.S. 464, 469, 473–74 (1977).

Due Process Clause affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, it does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom."³⁹ Furthermore, in the case of *Youngberg v. Romeo*, the Court explained that "a State is under no constitutional duty to provide substantive services for those within its border," and cited *Maher* and *Harris* to support its position.⁴⁰

The United States Supreme Court has, however, held that a right to a minimal amount of medical care exists for persons who are placed under government control so as to make them dependent on the government for health care, but the Court has not based such a right on a fundamental right to health.⁴¹ Although the Court could have couched the right of prisoners, suspects apprehended by the police, and mental health patients to medical care as a fundamental human right protected implicitly by the Constitution, and interpreted the Eighth Amendment or the Due Process Clause of the Fourteenth Amendment accordingly to protect the right to health, it chose not to do so.⁴² Prisoners are entitled to adequate food, clothing, shelter, and medical care, and prison officials must take reasonable steps to protect the prisoners' safety under the Cruel and Unusual Punishment Clause of the Eighth Amendment.⁴³ The Supreme Court has held that "deliberate indifference to serious medical needs of prisoners constitutes the 'unnecessary and wanton infliction of pain,' . . . proscribed by the Eighth Amendment," because the denial of medical care can result in pain and suffering and can even amount to torture and death.⁴⁴

The aforementioned opinions of the Supreme Court reflect an acknowledgement by the Court that health care deserves a special status amongst all goods generally if the government constitutionally must provide adequate health care for those with limited freedoms such as prisoners, suspects apprehended by the police, and mental health patients. In contrast, many people in the United States who the government has not deprived of any freedoms are not protected by a constitutionally mandated right to health guaranteeing them the adequate care prisoners receive, and thus are not able to access or utilize health care due to indigence, legal status, and other barriers. However, apart from the Constitution's prescriptions, the legislative and executive branches are free to protect these people by enacting additional requirements for the provision of medical care that are not constitutionally required. Unfortunately, the political branches of the government have not provided that protection and continue to perpetuate the tradition of considering health care a privilege. Although some legislative steps have been taken toward

39. *Harris v. McRae*, 448 U.S. 297, 317-18 (1980).

40. *Youngberg v. Romeo ex rel. Romeo*, 457 U.S. 307, 317 (1982).

41. *Gunnar*, *supra* note 29, at 162-64.

42. *Id.* at 163-64.

43. *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).

44. *Estelle v. Gamble*, 429 U.S. 97, 103-04 (1976) (citing *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)).

establishing a right to care, those efforts have fallen far short of mandating a human right to health.

2. *Federally Mandated Assistance: Medicare and Medicaid*

In 1965, President Lyndon B. Johnson took a large step away from an exclusively private health care system and moved the country towards accepting the idea of health as a right, even for the country's disenfranchised people, by signing an amendment to the Social Security Act creating the Medicare (Title XVIII) and Medicaid (Title XIX) programs for the elderly (defined as those over the age of 65) and the poor (defined differently by each state) respectively.⁴⁵ Although the enactment of Medicare and Medicaid programs demonstrated a commitment to provide the elderly and the poor with at least a safety net, it has since become a symbol of the status of health care as a privilege in the country, since only certain governmentally mandated categories of people qualify for public Medicare and Medicaid programs.⁴⁶ This categorization necessarily excludes millions of Americans who do not qualify for those programs, such as those who are not designated as poor enough to receive Medicaid assistance, but are too poor to afford their own private health insurance for themselves or their families and are not offered insurance through employment.⁴⁷ The present categorization also excludes millions of immigrants to the United States who may not receive federal assistance through these programs due to federally imposed restrictions such as those found in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, as will be discussed further below. Today, the spirit left by Johnson's legacy of Medicare and Medicaid has not been furthered by his successors, as the United States remains stuck in the older paradigm of viewing health care as a privilege conferred on only some in the country, instead of as a human right. Thus, the neediest people are frequently categorically excluded from public health care assistance, leaving millions in the United States without access to health care.

The historical view of health care as a privilege is still strongly present in the country, and federal actions show no signs of moving towards a right to health. Recently, as part of the Deficit Reduction Act, which President George W. Bush signed into law in February of 2006, new regulations took effect on July 1, 2006, requiring fifty million Americans who wish to apply or annually re-enroll for Medicare benefits to prove their citizenship through a passport or birth certificate.⁴⁸ This requirement also applies to newborns of undocumented mothers who must now file an application for their American citizen child along with proof of their citizenship in the form of a birth certificate, which can take weeks to ob-

45. See 42 U.S.C. § 1395 (2002) (current version of Medicare); 42 U.S.C. § 1396 (2002) (Medicaid).

46. See 42 U.S.C. § 1396 (Medicaid).

47. CARMALT & ZAIDIB, *supra* note 11, at 15.

48. Susan Levine & Mary Otto, *Medicaid Rule Called A Threat to Millions: Proof of Citizenship Needed for Benefits*, WASH. POST, June 30, 2006, at A1.

tain.⁴⁹ Due to this requirement, Medicaid cannot cover any services for the newborn, such as necessary immunizations, preventive care, and treatment, until the application is filed, which may not happen until days, weeks, or months after the birth, and could in fact never occur due to the undocumented parents' fears of being reported to immigration officials if they go to the state welfare offices to file the application.⁵⁰ Although regulation changes were meant to reduce fraud by undocumented immigrants, a federal inspector general's report concluded that little fraud of this sort occurred by noncitizens and now many worry that the new requirement will harm millions of poor and elderly United States citizens who are eligible to receive benefits, but will not be able to show appropriate documentation.⁵¹ Thus, increases in the number of immigrants, rather than leading to a recognition that these immigrants are the new generation of poor and disenfranchised people in the country who need help obtaining health care, are actually causing new and old American citizens to suffer by mounting hurdles to care that some will not be able to overcome. Without government aid, costly medical insurance, an absolute necessity for adequate care in the American system, is unaffordable for many families and has left millions of Americans without insurance. This new regulation further demonstrates the privileged status of health care, such that the federal government is erecting barriers to care not only for immigrants, but is even preventing its own citizens from accessing their international human right to health.

II. BARRIERS IMMIGRANTS FACE IN ACCESSING THEIR RIGHT TO HEALTH CARE

Despite its status as a leader in the field of medical advances and extraordinary care for those who can afford it, the United States is not meeting the requisite level of health care for all in the international arena of human rights, due to its policies which limit access to care and compromise the quality of health care. As a signatory to the ICESCR in 1977, the United States stated its commitment in front of the international community to uphold the values in the treaty.⁵² Under the ICESCR, the United States is "obligat[ed] to *respect* the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services; [and] abstaining from enforcing discriminatory practices as a State policy."⁵³ Although the Supreme Court has recognized the rights of prisoners and detainees to health services, as the treaty provides, it has not extended equal access to minorities, asylum seekers, and illegal immigrants to curative health

49. Robert Pear, *Medicaid Wants Citizenship Proof for Infant Care*, N.Y. TIMES, Nov. 3, 2006.

50. *Id.*

51. Levine & Otto, *supra* note 48, at A1.

52. See Ratification Status, *supra* note 21, at 11.

53. U.N. CESCR, *General Comment No. 14* (2000), *supra* note 20, at ¶ 34.

care, and federal legislation has completely denied the right of illegal immigrants to preventative care. Since access to health care can be defined as “factors that influence the ease with which medical care can be obtained,”⁵⁴ whether an individual can physically access care does not fulfill a duty to provide equal access to health care. Federal policies that perpetuate racial, cultural, and linguistic barriers to care thus also prevent equal access to medical care. These barriers prevent all people in the United States from receiving the level of meaningful health care internationally mandated as a necessary human right, especially for individuals who have to deal with both types of access issues, such as many immigrants who lack physical access due to indigence and legal status and have significant racial, cultural, and linguistic hurdles to overcome. As the number of immigrants in the United States steadily increases, more people will be marginalized by American health care policies and deprived of their international human right to health. This trend particularly in Latino immigration must be addressed since, “[w]hen ethnicity and insurance status are combined, rural uninsured Latinos are among the least likely individuals to receive healthcare,” such that the number of people without health care will continue to increase.⁵⁵ The issues immigrants face in obtaining medical care highlight the consequences of a system that views health care as a privilege.⁵⁶

A. BARRIERS TO PHYSICALLY ACCESSING MEDICAL CARE

The status of health care as a privilege in the United States can be seen through the barriers that federal law and policies place on immigrants’ access to health care in the country. Under common law, a physician has no duty to treat any patient who had not yet formed a physician-patient relationship with them.⁵⁷ Traditionally, the same no duty rule applied to private hospitals, which had no duty to admit a patient, regardless of whether an emergency condition existed, and thus could refuse any patient for any reason at all, including inability to pay.⁵⁸ This no duty to aid rule was famously articulated in the case of *Wilmington General Hospital v. Manlove*,⁵⁹ where the Supreme Court of Delaware held that “[a] private hospital owes the public no duty to accept any patient not desired by it, and it is not necessary to assign any reason for its refusal to accept a

54. Windsor W. Sherrill et al., *Educational and Health Services Innovation to Improve Care for Rural Hispanic Communities in the U.S.*, 18 EDUC. FOR HEALTH 356, 357 (2005).

55. *Id.* at 358.

56. Although a myriad of other barriers to receiving health care exist in the immigrant population, such as differing cultural attitudes to medicine and care, racial and ethnic prejudices of providers, the undocumented individuals’ fear of discovery and deportation, and the fear of those who are documented of losing their status by becoming a ‘public charge’ if they use public funding, this Article principally examines the explicit government policies which limit immigrants’ access to care.

57. SUSAN S. ROBFEL ET AL., TREATISE ON HEALTH CARE LAW § 11.03 (Matthew Bender & Co. 2005).

58. *Id.*

59. *Wilmington Gen. Hosp. v. Manlove ex rel. Manlove*, 174 A.2d 135, 138, 141 (Del. 1961).

patient for hospital service.”⁶⁰ However, *Manlove* recognized the dangers of refusing a request for emergency care because “a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid,”⁶¹ and thus held that a hospital was under a duty to provide emergency care, “when: (1) an ‘unmistakable emergency’ exist[ed]; (2) the hospital ha[d] a ‘well-established’ custom of providing emergency care; and (3) the patient relie[d] on the hospital’s usual practice of providing emergency care.”⁶² However, without a strict definition of “unmistakable emergency,” *Manlove*’s loose standard led to frequent denials of even emergency care, with deadly consequences, and common “patient dumping,”⁶³ or “a hospital’s refusal to provide emergency medical screening exams or the transfer of an unstable patient on grounds unrelated to the patient’s need for the services or the hospital’s ability to provide them.”⁶⁴

1. *The Failed Right to Emergency Care under EMTALA*

The practice of patient dumping shocked the consciences of many representatives in Congress and led to the passage of the Emergency Medical Treatment and Active Labor Act (“EMTALA”) in 1986.⁶⁵ The EMTALA provisions apply to any Medicare-participating hospital with an emergency medical department,⁶⁶ and provide:

[I]f any individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual’s behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital’s emergency department . . . to determine whether or not an emergency medical condition . . . exists.⁶⁷

60. *Id.* at 138.

61. *Id.* at 139.

62. Sana Loue, *Access to Health Care and the Undocumented Alien*, 13 J. LEGAL MED. 271, 278–79 (1992).

63. *See id.* at 280–81 (citing the case of a young woman, eight months pregnant, with a ruptured uterus who was denied care by two private Texas hospitals, leading to both her and her child’s death); Svetlana Lebedinski, *EMTALA: Treatment of Undocumented Aliens and the Financial Burden it Places on Hospitals*, 7 J.L. Soc’y 146, 146 (2005).

64. Sara Rosenbaum & Brian Kamoie, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 591 (2003).

65. Lebedinski, *supra* note 63, at 146.

66. U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Regulations and Guidance, EMTALA Overview, <http://www.cms.hhs.gov/EMTALA/> (last visited Sept. 15, 2007).

67. 42 U.S.C. § 1395dd(a) (2003). The Act further defines “emergency medical condition” as

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or (B) with respect to a pregnant woman who is having contractions—(i) that there

If the examination reveals that an emergency medical condition does in fact exist, the hospital may not transfer or discharge the patient without first stabilizing the patient's condition, and may only transfer the patient to another medical facility under the limited circumstances described in the statute.⁶⁸

When faced with horrible examples of death and disease due to the refusal of health care for lack of ability to pay, Congress could have used EMTALA as the perfect avenue to provide a minimal level of health care for everyone in the United States and fulfill its international commitments to provide a human right to health in the country. Senator Durenberger (a cosponsor of the Senate version of EMTALA), for example, was moved to sponsor the bill because he believed, "the practice of rejecting indigent patients in life threatening situations for economic reasons alone is unconscionable."⁶⁹ The spirit of providing at least emergency care as a minimal part of the human right to health was certainly present during EMTALA's passage, and is seen in Representative Bilirakis's statement that "no person should be denied emergency health care or hospital admittance because of a lack of money or insurance."⁷⁰ However, if Congress did intend EMTALA to delineate and safeguard a right to a minimal level of health, it did not succeed through the passage of that Act.

While multiple authors, policy makers, and perhaps most of those impacted by EMTALA's provisions have seen the statute as providing an unfettered right of access to emergency care for every single person in the United States,⁷¹ and understand that to clearly be the congressional intent behind its passage,⁷² the statute's ambiguous language became subject to judicial interpretation which has greatly reduced its effectiveness in providing universal access to emergency care.⁷³ In fact, several judicial

is inadequate time to effect a safe transfer to another hospital before delivery, or (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

42 U.S.C. § 1395dd(e)(1).

68. See 42 U.S.C. § 1395dd(b), (c).

69. 131 CONG. REC. S13892-01 (daily ed. Oct. 23, 1985), *quoted in* Nathanael J. Scheer, Comment, *Keeping the Promise: Financing EMTALA's Guarantee of Emergency Medical Care for Undocumented Aliens in Arizona*, 35 ARIZ. ST. L.J. 1413, 1416 (2003).

70. 131 CONG. REC. H9487-02 (daily ed. Oct. 31, 1985), *quoted in* Scheer, *supra* note 69, at 1416.

71. See, e.g., Lebedinski, *supra* note 63, at 146 ("EMTALA was a second attempt by Congress to provide access to emergency care for the community as a whole."); *id.* at 159 ("Under EMTALA, undocumented aliens are entitled to medical emergency care regardless of how long they have been residing in the United States."). See Scheer, *supra* note 69, at 1415 ("EMTALA was conceived of as a way of guaranteeing emergency medical care to all individuals who present themselves at an emergency room with an emergency medical condition").

72. Mark J. Garwin, *Immunity in the Absence of Charity: EMTALA and the Eleventh Amendment*, 23 S. ILL. U. L. J. 1, 4 (1998) ("EMTALA was expressly enacted for the protection of patients who were denied emergency room treatment because of their indigent or uninsured status").

73. Dana E. Schaffner, Note, *EMTALA: All Bark and No Bite*, 2005 U. ILL. L. REV. 1021, 1023 (reviewing the lack of uniformity among the federal circuits in EMTALA inter-

opinions have stripped EMTALA of its force as a grant of emergency care rights, and instead interpreted the statute as merely a non-transfer statute.⁷⁴ For example, while a cursory reading of the stabilization requirement of the Act seems to require a hospital to stabilize all patients it determines to have an emergency medical condition, the Eleventh Circuit read the plain language of the statute as limiting that duty to only apply in the case of a transfer, and held that "[t]here is no duty under EMTALA to provide stabilization treatment to a patient with an emergency medical condition who is not transferred."⁷⁵ Additionally, conflicts in judicial interpretation of the duration of liability for stabilization requirements show the possibility for large differences in the emergency care provision, depending on which competing interpretations is applied. For example, while the Ninth Circuit held that a hospital's duty to stabilize is accomplished at the moment that a patient is admitted for patient care, based on the court's reading of EMTALA as an anti-transfer statute,⁷⁶ the Sixth Circuit interpreted the EMTALA obligations as extending well beyond admission, holding that "once a patient is found to suffer from an emergency medical condition in the emergency room, she cannot be discharged until the condition is stabilized, regardless of whether the patient stays in the emergency room."⁷⁷ The Sixth Circuit rule anticipated the possibility that a hospital knows the emergency condition of a patient and admits the patient into the hospital, but does not actually stabilize or treat the patient in any way and yet escapes liability under EMTALA.⁷⁸

Lastly, the Fourth Circuit stated that:

The avowed purpose of EMTALA was not to guarantee that all patients are properly diagnosed, or even to ensure that they receive adequate care, but instead to provide an "adequate first response to a medical crisis" for all patients and "send a clear signal to the hospital community . . . that all Americans, regardless of wealth or status, should know that a hospital will provide what services it can when they are truly in physical distress."⁷⁹

pretation and arguing that the 2003 revised regulations to EMTALA will produce a negative effect on uninsured and underinsured persons' access to emergency medical care); see also Garwin, *supra* note 72, at 4 (discussing the varying judicial interpretations of EMTALA provisions and the judicial disregard for the legislative intent to provide emergency care for indigents).

74. *Harry v. Marchant*, 291 F.3d 767, 775 (11th Cir. 2002); *Bryant v. Adventist Health Sys./W.*, 289 F.3d 1162, 1168 (9th Cir. 2002).

75. *Marchant*, 291 F.3d at 767-69 (in which a woman who was brought to the emergency room by the Miami-Dade Fire Rescue and diagnosed with "pneumonia rule out sepsis" was not admitted into the ICU for hours on the advice of the emergency room physician and was later not administered prescribed antibiotics, resulting in her death from respiratory and cardiac failure).

76. *Bryant*, 289 F.3d at 1168.

77. *Thornton v. Sw. Detroit Hosp.*, 895 F.2d 1131, 1134 (6th Cir. 1990).

78. *Id.* at 1135. "Hospitals may not circumvent the requirements of the Act merely by admitting an emergency room patient to the hospital, then immediately discharging that patient. Emergency care must be given until the patient's emergency medical condition is stabilized."

79. *Baber v. Hosp. Corp. of Am.*, 977 F.2d 872, 880 (4th Cir. 1992) (quoting 131 CONG. REC. S13904 (Oct. 23, 1985) (statement of Senator Durenberger)).

Thus, using the statements of Senator Durenberger (who had gone on to say that rejecting patients for lack of funds was “unconscionable”)⁸⁰ which could otherwise demonstrate congressional intent to provide universal emergency care, the Fourth Circuit instead limited the Act so that it only guarantees a nondiscriminatory emergency medical response and does not prescribe any right to a minimal level of adequate medical treatment.⁸¹ The 2003 revised regulations governing the Act released by the Centers for Medicare & Medicaid Services (CMS), of the Department of Health and Human Services (HHS), and the Office of the Inspector General (OIG) further limit the scope of a hospital’s obligation to provide emergency care to those who come through its doors and further reduce patient access to emergency medical care.⁸²

Although EMTALA has had the effect of increasing immigrant access to emergency care in hospitals regardless of a patient’s immigration status and insurance coverage,⁸³ its language does not protect a human right to emergency health care or a right to a minimal standard of care, as can be seen through the myriad of judicial interpretations of the Act that have left it with little of its intended force to protect the rights of the indigent and uninsured. By passing EMTALA, Congress recognized the value of at least a certain level of health care for all humans, and perhaps it intended to codify those rights, but it has not since fulfilled its international responsibilities and has instead erected further barriers to health care access for certain individuals it has deemed unworthy to receive care.

2. *The Lack of Non-Emergency Care Rights and PRWORA*

Access to emergency screening in hospitals and stabilization before being transferred does not rise to a level that meets the international standards dictating a right to health for immigrants in the United States who lack insurance. The uninsured do not receive regular medical care both because of the high costs of health care in the country and because doctors may and often do refuse to treat the uninsured, leaving hospital emergency rooms as their primary source of care.⁸⁴ Uninsured aliens especially are less likely to receive preventative, prenatal, and other non-emergency medical care and frequently go to hospital emergency rooms for illnesses that could have been prevented with prior care.⁸⁵ Instead of ameliorating these problems by providing greater access to non-emergency health care for all people, including immigrants, Congress in 1996 took a major step away from recognizing a human right to health when it enacted the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA, or 1996 Welfare Reform Act),⁸⁶ leaving

80. See 131 CONG. REC. S13892-01, *supra* note 69.

81. Schaffner, *supra* note 73, at 1031.

82. *Id.* at 1023, 1039.

83. Lebedinski, *supra* note 63, at 156.

84. Schaffner, *supra* note 73, at 1022.

85. Lebedinski, *supra* note 63, at 159–60.

86. 8 U.S.C. § 1601 (2005).

thousands of alien immigrants without government health insurance and thus without care.⁸⁷

Congress passed PRWORA with an intent to eliminate public benefits for illegal immigrants, since the statute denies state and local benefits to unqualified aliens.⁸⁸ The Act defines qualified aliens as including Lawful Permanent Residents ("LPRs"), asylees and refugees, among others, but intentionally excludes undocumented aliens.⁸⁹ It also does not cover temporary residents (nonimmigrants), aliens granted temporary protected status, Family Unity beneficiaries, spouses and children with pending adjustment of status claims, cancellation of removal and asylees applicants, and several other categories of aliens in the United States.⁹⁰ The Act erects a barrier to health care for immigrants by denying state and local benefits for ineligible aliens and provides exceptions only for emergency care, immunizations, treatment for communicable diseases, disaster relief, and programs which may be specified by the Attorney General.⁹¹ PRWORA does, however, allow states to pass legislation "which affirmatively provides . . . eligibility" to undocumented immigrants for any state or local benefits,⁹² leaving immigrants at the will of the legislatures and sentiments toward immigrants in the individual states in which they reside to provide them with a way to access non-emergency care. Additionally, PRWORA further hindered immigrant access to care by enacting waiting periods for immigrants to receive Medicaid benefits. The Act prescribes that LPRs who entered the country after August 22, 1996 can only apply for Medicaid benefits after five years of having entered the country legally, and can only receive benefits at states' discretion, as is the case for LPRs who were in the country as of August 22, 1996.⁹³ Under PROWRA, refugees and asylees are not eligible for Medicaid assistance until seven years after their date of entry, and, as previously discussed, all aliens holding legal nonimmigrant status as well, as all undocumented immigrants, are completely barred from receiving assistance through these programs.⁹⁴

87. Rose Cuison Villazor, *Community Lawyering: An Approach to Addressing Inequalities in Access to Health Care for Poor, of Color and Immigrant Communities*, 8 N.Y.U. J. LEGIS. & PUB. POL'Y 35, 44 (2004).

88. Neill, *supra* note 8, at 420.

89. See 8 U.S.C. § 1641 (2005).

90. Charles Wheeler & Tanya Broder, *Immigrant Eligibility for Public Benefits*, in IMMIGRATION & NATIONALITY LAW HANDBOOK 759, 761 (Am. Immigration Lawyers Ass'n 2005-06 ed.), available at http://www.nilc.org/immspbs/special/imm_elig_for_pub_bens_aila_0305.pdf.

91. See 8 U.S.C. § 1641.

92. 8 U.S.C. § 1621(d) (2005). "A State may provide that an alien who is not lawfully present in the United States is eligible for any State or local public benefit for which such alien would otherwise be ineligible under subsection (a) of this section only through the enactment of a State law after August 22, 1996, which affirmatively provides for such eligibility." *Id.*

93. 8 U.S.C. § 1612 (2005 & Supp. 2007).

94. See *id.*

3. A Look at Texas Provides Hope

The impacts of federal barriers to health care are usually most starkly noticed close to home in the communities that are faced with the choice of either treating an individual without insurance or public benefits preventatively for free, or having to wait until that person has an affirmative legal claim to care when his condition becomes life-threatening and is thus not only more expensive to treat, but has put his health and life at grave risk. Public hospitals in many Texas cities have been providing non-emergency care for undocumented immigrants for years, and thus have recognized the need to provide basic health care to people in their community, regardless of a person's legal status.⁹⁵ In 2001, when the Harris County Hospital District decided to expand its preventative health care benefits to undocumented immigrants, it asked then-Texas Attorney General John Cornyn to make sure that policy was in accordance with applicable state and federal laws.⁹⁶ In a response that came as a shock to hospital administrators across the state, Cornyn stated that Texas had not enacted a law "affirmatively" providing public benefits to undocumented immigrants, such that PRWORA precluded hospitals from providing non-emergency care to undocumented immigrants.⁹⁷ Although an amendment to the Texas Family Code allowed the Texas Department of Protective and Regulatory services to provide public funds to anyone who was eligible, regardless of their immigration status,⁹⁸ and the Indigent Health Care and Treatment Act allowed public hospital districts to provide residents of the districts with free or discounted health care regardless of legal immigration status,⁹⁹ Cornyn stated that these laws did not "expressly state the legislature's intent that undocumented aliens are to be eligible for certain public benefits."¹⁰⁰

To remedy the situation of uncertainty caused by the Attorney General's opinion and the lack of care for hundreds of undocumented immigrants who were turned away from hospitals as a result of Cornyn's analysis,¹⁰¹ the Texas legislature amended the Texas Health & Safety Code providing:

As authorized by 8 U.S.C. Section 1621(d), this chapter affirmatively establishes eligibility for a person who would otherwise be ineligible under 8 U.S.C. Section 1621(a), provided that only local funds are utilized for the provision of nonemergency public health benefits. A person is not considered a resident of a governmental entity or hospital district if the person attempted to establish residence solely to

95. Neill, *supra* note 8, at 422.

96. *Id.* at 421.

97. *Id.*; see Op. Tex. Att'y Gen. No. JC-0394 (July 10, 2001).

98. Op. Tex. Att'y Gen. No. JC-0394 (July 10, 2001) (discussing TEX. FAM. CODE ANN. § 264.004(c) (Vernon Supp. 2001)).

99. See TEX. HEALTH & SAFETY CODE ANN. §§ 61.001-.008 (Vernon 2000); see also Op. Tex. Att'y Gen. No. JM-1021 (Feb. 24, 1989).

100. Op. Tex. Att'y Gen. No. JC-0394 (July 10, 2001).

101. Neill, *supra* note 8, at 423.

obtain health care assistance.¹⁰²

Following this enactment, another opinion of the Texas Attorney General, issued on July 22, 2004, answered the question of whether this provision requires or merely permits hospital districts to provide non-emergency health benefits to undocumented immigrants.¹⁰³ The Attorney General's analysis focused on the word "eligibility" as used in the statute and concluded that it connoted fewer rights than the word "entitled" would, such that hospital districts are not required to provide non-emergency care under that statute.¹⁰⁴ Thus, while federal and higher state officials have attempted to curtail the provision of health care benefits to immigrants, local hospitals who see the day-to-day impacts of the policies regarding health care as a privilege continue to push for access to preventative care for all their residents, a position which the Texas legislature advanced by "affirmatively" providing all immigrants with access to benefits.

4. *The United States Is Not Meeting International Health Standards*

Federally however, the United States legislature has not responded to the health care needs of its residents. Millions of uninsured immigrants are thus without access to non-emergency health care, such as LPRs, asylees, and refugees who await eligibility for Medicare benefits for years, as well as undocumented immigrants who will never qualify. In contrast, the health of all humans cannot wait, and not providing access to preventative, non-emergency care is a gross violation of national and international opinions on human rights, regardless of a person's legal status. The Supreme Court has even articulated the seriousness and cruelty of denying preventative care stating:

To allow a serious illness to go untreated until it requires emergency hospitalization is to subject the sufferer to the danger of a substantial and irrevocable deterioration in his health. Cancer, heart disease, or respiratory illness, if untreated for a year, may become all but irreversible paths to pain, disability, and even loss of life. The denial of medical care is all the more cruel in this context, falling as it does on indigents who are often without the means to obtain alternative treatment.¹⁰⁵

Not providing preventative care is denying the right to health to all immigrants who wait for years for benefit eligibility and to those who can never access non-emergency care at all because of their poor legal and financial situation. "The illegals are human beings," and "[u]nderstanding that undocumented immigrants are human beings makes it easier to see that providing them basic preventative medicine and health care is not a

102. TEX. HEALTH & SAFETY CODE ANN. § 285.201 (Vernon Supp. 2004).

103. Op. Tex. Att'y Gen. No. GA-0219 (July 22, 2004).

104. See *id.*

105. *Mem'l Hosp. v. Maricopa County*, 415 U.S. 250, 261 (1974).

right based on citizenship, but a right as a human being.”¹⁰⁶ The United States thus has a moral and international obligation to provide all Americans and all immigrants with comprehensive access to care. By denying care to immigrants, the country is not living up to its political commitments and ideals it adhered its signature to in the ICESCR, the Convention on the Rights of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women: recognizing the human right to health care. The United States is also violating its obligations under the International Convention on the Elimination of All Forms of Racial Discrimination by explicitly discriminating against immigrants’ access to health care on the basis of national origin in PROWRA, which is prohibited in the treaty and thus violates international law as recognized both inside and outside the country.¹⁰⁷ Discrimination in access to health care services also exists on a de-facto basis, as racial and ethnic minorities still receive poorer health care services than Anglo-Americans, and racial minorities and immigrants compose the majority of those who are uninsured.¹⁰⁸ The country must begin honoring its international obligations by taking steps to end discrimination in the provision of health care and honoring a human right to health.

B. BARRIERS TO MEANINGFUL CARE ACCESS

Another discriminatory barrier blocking the path of attaining a human right to health care for all people in the United States is present even after issues of physical access to medical care are resolved. Even if immigrants are physically able to access health care resources, whether emergency or preventative care, they are often not able to fully use those resources due to a language barrier that is often present, and thus lack access to *meaningful* health care treatment.¹⁰⁹ In 2000, forty-seven million people, or 18% of people in the United States age five and older reported on the United States Census that they spoke a language other than English at home.¹¹⁰ Additionally, 8.1% of United States residents have limited English proficiency (“LEP”), speaking English less than “very well.”¹¹¹ Both of these statistics have grown in the last twenty years, since only 14% of people spoke a language other than English at home in 1990, and 11% in 1980, with only 4.8% of those being LEPs in 1980, versus 6.1% in 1990, and these trends show no sign of stopping.¹¹² Language difficulties account for problems in attaining physical access to care, since, for example, 19% of Latino patients do not even seek out

106. Neill, *supra* note 8, at 425 (advancing moral and economic arguments for providing preventative health care for undocumented immigrants).

107. See ICEAFRD, *supra* note 15, at art. V.

108. Villazor, *supra* note 87, at 40, 43.

109. See Sherrill et al., *supra* note 54, at 357; Villazor, *supra* note 87, at 41.

110. HYON B. SHIN & ROSALIND BRUNO, U.S. CENSUS BUREAU, CENSUS 2000 BRIEF, LANGUAGE USE AND ENGLISH SPEAKING ABILITY: 2000 1 (2003), available at <http://www.census.gov/prod/2003pubs/c2kbr-29.pdf>.

111. *Id.* at 3.

112. See *id.* at 2.

medical treatment due to a perceived language barrier.¹¹³ However, since patient-physician communication is an essential part of medical care, and language is an important part of communication, any sort of meaningful care is in jeopardy if a strong language barrier exists, as it would for the more than twenty-one million individuals who have LEP in the country.¹¹⁴ Countless stories exist of miscommunication and translation errors which have not only led to deficient medical care, but to such extreme consequences as permanent disability and death. For example, a Spanish-speaking eighteen-year-old former high school athlete told his girlfriend he felt “intoxicado” (he intended to say he felt “nauseated”), but when the girlfriend and her mother told the non-Spanish-speaking paramedics the term, they assumed it meant “intoxicated” from being “high on drugs.”¹¹⁵ After more than thirty-six hours in the hospital being treated for a drug overdose, a reevaluation revealed that he actually suffered from acute subdural hematoma secondary to a ruptured artery and other brain injuries, from which he later woke up quadriplegic.¹¹⁶ Due to the errors in care, the hospital became subject to a \$71 million malpractice settlement.¹¹⁷ In yet another case, a thirteen-year-old girl who could not speak English visited the emergency room at a hospital which did not provide an interpreter and shortly died of a ruptured appendicitis due to both language barriers and discriminatory stereotyping by the evaluating physician.¹¹⁸ Since she was not able to explain her symptoms, the hospital jumped to conclusions that the abdominal pain of a thirteen-year-old Hispanic girl was likely due to a pregnancy, and only gave her a pregnancy exam rather than testing her for an appendicitis, which could have saved her life.¹¹⁹ These examples demonstrate the linguistic and ethnic discrimination that exists in health care situations in the United States which can unfortunately lead to disastrous results. These results show the latent presence of national origin discrimination in the provision of care, which is against the country’s own principles as well as its international obligations and can thus not be tolerated when all people are entitled to an international human right to meaningful health care.

113. Sherrill et al., *supra* note 54, at 358.

114. Villazor, *supra* note 87, at 41.

115. Glenn Flores, *Language Barriers to Health Care in the United States*, 355 NEW ENG. J. MED. 229, 230 (2006) (discussing several other tragic cases of communication issues hindering care, such as the case of a mother who told a resident that her 2 year-old girl “se pegó” (she hit herself) when she fell off her tricycle, but which the resident understood to mean “I hit her” and thus had the mother sign over custody of her two children to the Department of Social Services without an interpreter present); Hilary Abramson, *Next Great Immigration Hurdle—The Right to a Medical Interpreter*, NEW AM. MEDIA, May 30, 2006, http://news.newamericamedia.org/news/view_article.html?article_id=a2ccf312598b4820d1d0ac25265fc91e.

116. Flores, *supra* note 115, at 230; Abramson *supra* note 115.

117. Flores, *supra* note 115, at 230.

118. Barbara Plantiko, Comment, *Not-So-Equal Protection: Securing Individuals of Limited English Proficiency with Meaningful Access to Medical Services*, 32 GOLDEN GATE U. L. REV. 239, 240 (2002).

119. *Id.*

1. *Executive Order 13166: Bringing Language Assistance to Health Care*

In the same way that immigrants should not be subjected to many years of waiting for health care benefits in order to get physical access to care, they also cannot be expected to learn English the moment they cross the border into the United States, as it takes several years to learn a language “very well,” as indicated by the Census, and certainly well enough to use in a medical care setting. President Clinton recognized these problems and issued Executive Order No. 13166 on August 11, 2000 to end national origin discrimination under Title VI of the Civil Rights Act of 1964¹²⁰ in health care settings.¹²¹ President Bush’s administration has also since committed its support to advancing the provisions of that Executive Order.¹²² Executive Order 13166 directs each federal agency to implement a plan to improve access to their agencies by LEP persons so that they can “meaningfully access the agency’s programs and activities.”¹²³ Based on the Department of Justice’s policy directives on the order, the Department of Health and Human Services issued LEP guidance for providers with a variety of “language assistance options” to meet the communication needs of LEP individuals, including: hiring bilingual staff, staff interpreters, contract interpreters, community volunteers (if they meet the mandated competency requirements), and using telephone interpreter lines.¹²⁴ It also addresses a large problem in LEP care and states that Title VI liability could attach if a provider “requires, suggests, or encourages an LEP person to use friends, minor children, or family members as interpreters, as this could compromise the effectiveness of the service.”¹²⁵ The Policy Guidance goes on to state:

[u]se of such persons could result in a breach of confidentiality or reluctance on the part of individuals to reveal personal information critical to their situations. In a medical setting, this reluctance could have serious, even life threatening, consequences. In addition, family and friends usually are not competent to act as interpreters, since they are often insufficiently proficient in both languages, unskilled in

120. 42 U.S.C. § 2000(d) (2000).

121. Exec. Order No. 13166, 65 Fed. Reg. 50121 (Aug. 11, 2000).

122. Memorandum from Ralph F. Boyd, Jr., Assistant Attorney General, to Heads of Federal Agencies, General Counsels, and Civil Rights Directors concerning Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) (July 8, 2002), <http://www.usdoj.gov/crt/cor/lep/BoydJul82002.pdf> (asking the heads of federal agencies for “continued assistance in implementing Executive Order 13166 to ensure meaningful access for LEP individuals to important federal and federally funded rights, information, benefits, and services”); Memorandum from Ralph F. Boyd, Jr., Assistant Attorney General, to Heads of Departments and Agencies regarding Executive Order 13166 (Improving Access to Services for Persons with Limited English Proficiency) (Oct. 26, 2001), <http://www.usdoj.gov/crt/cor/lep/Oct26memorandum.pdf>.

123. Exec. Order No. 13166, *supra* note 121.

124. Policy Guidance, Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency, <http://www.hhs.gov/ocr/lep/guide.html> (last visited Sept. 17, 2007).

125. *Id.*

interpretation, and unfamiliar with specialized terminology.¹²⁶

Executive Order 13166 once more shows the existence of a desire in public efforts to move towards a right to health care by going beyond physical access to care and attempting to provide meaningful access to treatment for LEP individuals. However, this federal attempt has largely failed, due to its problems with funding and enforcement, since most of the states containing the largest numbers of patients with LEP have not allocated state funds for interpreter services.¹²⁷ Physicians and hospitals have therefore found the cost of providing translation services to be a difficult burden they many times cannot meet.¹²⁸ Additionally, there is no indication that this potentially dangerous situation will be remedied, since the enforcement of the existing guidelines has been greatly hindered by the landmark case of *Alexander v. Sandoval*.¹²⁹ In that case the Supreme Court eliminated a private cause of action for disparate impact claims under Title VI, such as those that would be brought against a hospital or physician who did not provide translation services for LEP patients.¹³⁰ Thus, health and civil rights activists who wish to enforce the language rights of LEP individuals and eliminate ethnic and racial discrimination in medical treatment now must turn to new avenues to seek the provision of meaningful access to care.¹³¹

Lastly, just as recent federal regulations reflect a policy trend of providing less physical access to care for immigrants, provisions establishing a national English-only policy in the Senate's recently passed immigration reform legislation would restrict access to meaningful care and put the existing regulations assisting LEP individuals to access government services at great risk.¹³² The new legislation declares that "English is the national language of the United States,"¹³³ and provides:

126. *Id.*

127. See Flores, *supra* note 115, at 230. Some federal funds are available to pay for medical interpreter services, but providers may only receive those funds if their state has agreed to use their own Medicaid money which the federal government will match. Allison Keers-Sanchez, Commentary, *Mandatory Provision of Foreign Language Interpreters in Health Care Services*, 24 J. LEGAL MED. 557, 573 (2003). Presently only thirteen states (not including California, Arizona, or New Mexico, for example) match federal funds and provide reimbursement. Flores, *supra* note 115, at 230.

128. Keers-Sanchez, *supra* note 127, at 573; Siddharth Khanijou, *Rebalancing Health-care Inequities: Language Service Reimbursement May Ensure Meaningful Access to Care for LEP Patients*, 9 DEPAUL J. HEALTH CARE L. 855, 872-74 (2005).

129. *Alexander v. Sandoval*, 532 U.S. 275 (2001).

130. See *id.* at 293.

131. See Villazor, *supra* note 87, at 48 (suggesting community lawyering as a method to ensure that LEP persons receive language assistance and meaningful care). But see Paula Heine, Note, *Best Methods for Increasing Medical Translators for Limited English Proficient Patients: The Carrot or the Stick?*, 18 J. L. & HEALTH 71, 83-84 (2003-04) (arguing that greater private enforcement under Title VI would not assist LEP patients in rural America, where LEP individuals are currently not being provided translation services).

132. See Comprehensive Immigration Reform Act of 2006, S. 2611, 109th Cong. § 767 (2006).

133. *Id.* § 161 (entitled "Declaration of the national language").

The Government of the United States shall preserve and enhance the role of English as the national language of the United States of America. Unless otherwise authorized or provided by law, no person has a right, entitlement, or claim to have the Government of the United States or any of its officials or representatives act, communicate, perform or provide services, or provide materials in any language other than English. If exceptions are made, that does not create a legal entitlement to additional services in that language or any language other than English. If any forms are issued by the Federal Government in a language other than English (or such forms are completed in a language other than English), the English language version of the form is the sole authority for all legal purposes.¹³⁴

If this provision were found to be valid under Title VI, it would eliminate the current language assistance programs aiding LEP individuals in accessing all government services.

As the federal government continues to move in a direction which denies a human right to health for all its residents, several individual states have taken steps to recognize this right for their residents. California, for example, made sure to make the mandates in Executive Order 13166 permanent in its state by passing legislation requiring health care providers to make interpreters available to those who need them.¹³⁵ The state made this move based on its realization that quality care would otherwise be “difficult if not impossible.”¹³⁶ Other states must follow suit and make local changes to quickly bring meaningful health care to all of their residents.

III. MOVING TOWARDS A RIGHT TO HEALTH: LOCAL SOLUTIONS FOR TEXAS

As Governor Schwarzenegger’s recent proposal demonstrates, many states and local health care providers seem to be responding to the pressing need for universal health care as a right more quickly and more successfully than the federal government. Some lawmakers and commentators believe that states have been forced to take on a more active role, especially with regard to the immigration factor, because of the federal government’s failure to provide a new comprehensive immigration solution, such that states will continue to present “more solutions at the state level on this issue than we have ever seen before.”¹³⁷ California might be thought of as ahead of the crowd in dealing with the issue because the debate has gone beyond whether the state should provide services to its immigrant residents at all, and instead now focuses on the

134. *Id.* § 162 (entitled “Preserving and enhancing the role of the national language”).

135. Dymally-Alatorre Bilingual Services Act, CAL. GOV’T CODE §§ 7290–7299.8 (West 2006).

136. Elizabeth Weise, *Language Barriers Plague Hospitals*, USA TODAY, July 20, 2006, at 1A (quoting Cindy Ehnes of California’s Department of Managed Health Care).

137. Garry Boulard, *Immigration—Left to the States*, 32 ST. LEGISLATURES, Oct. 1, 2006, at 14, 15 (quoting John Keely, Director of Communications at the Center for Immigration Studies).

quantity and quality of services, since “some time ago the state leadership . . . decided they were just going to have to provide a certain level of services for the immigrant populations, and that was it.”¹³⁸ However, others see the presence of state policies regarding immigrant access to health care in a completely different light that acknowledges self-interested reasons for providing care to immigrants. For example, many also see the health care expenditures as “investments . . . that . . . are maintaining the health of a population or increasing its wage potential,” such as Representative Joseph Miro of Delaware, who recognizes that providing immigrants with health care is a responsibility that states should assume in exchange for the large benefits that come with the work that immigrants provide and its positive effect on the economy.¹³⁹ Whatever their motivations, several states have taken affirmative steps towards providing a right to health for their residents and honoring the international right in their own corner of the world.¹⁴⁰ Texas should follow suit and go even further to protect every human’s right to health, at least on a local level, by allowing everyone to physically access an adequate level of health care.

A. IMPROVING PHYSICAL ACCESS TO CARE: TEXAS’S UNIQUE POSITION TO PROVIDE REFORM

If Governor Schwarzenegger’s health care plan succeeds, California will join Maine, Massachusetts, Vermont, and Hawaii as states that seek to provide nearly universal health care, although none of those states have yet extended their “universal” vision of care to undocumented immigrant adults.¹⁴¹ However, complete universal coverage of both United States citizens and all immigrants could be a possibility in the future as many states are committed to making health care reforms a priority in 2007. Illinois, Colorado, Louisiana, Maine, Maryland, New Mexico, and Washington have formed commissions to address coverage expansion, and reforms and political leadership in Colorado, Florida, Indiana, Ohio, Oregon, Minnesota, New Jersey, and Wisconsin are considering expanding to a form of universal coverage as well.¹⁴² Texas should join these states in taking affirmative steps to recognize a human right to health.

Texas is not currently addressing its responsibilities to provide equal access to an adequate level of health for its residents, as a 2005 study by the State Health Access Data Assistance Center revealed that Texas has the highest percentage of uninsured residents among all states, with an

138. *Id.* at 17 (quoting Jean Ross, Executive Director of the California Budget Project).

139. *Id.*

140. National Conference of State Legislatures, *2007 Bills on Universal Health Coverage: Legislatures Fill in the Gaps*, <http://www.ncsl.org/programs/health/universalhealth2007.htm> (last visited Sept. 17, 2007).

141. Steinhauer, *supra* note 4, at A1.

142. National Conference of State Legislatures, *supra* note 140.

adult uninsurance rate of 30.7%.¹⁴³ Texas also had one of the highest levels of disparity in health care coverage rates between Anglo versus Hispanic adults in the state.¹⁴⁴ When one combines these statistics with the finding that 45% of uninsured adults in Texas were unable to afford to see a doctor for care when they needed to¹⁴⁵ and the fact that Texas is experiencing the second largest percentage of immigrant growth in the country after California,¹⁴⁶ it becomes evident that the state must consider reforming the current health care system to avoid the discriminatory outcome that has occurred and which will continue to result in the lack of necessary medical care for millions of people. A nonpartisan Task Force on Access to Health Care in Texas sponsored by all ten of the major academic health institutions in Texas issued a report in late 2006 entitled *Code Red: The Critical Condition of Health Care in Texas*.¹⁴⁷ The report noted Texas's position as the state with the highest number of uninsured people, as well as the fact that Texas has not taken full advantage of available federal matching funds to alleviate the burden of providing care to the uninsured, and proposed several legislative changes to remedy the finding that the current county-based approach to health care delivery was "inadequate, and inequitable."¹⁴⁸ The primary recommendation was that "Texas should adopt a principal that all individuals living in Texas should have access to adequate levels of health care"¹⁴⁹ and concluded that "[n]ow is the time for Texas to take *bold steps* to address the problems associated with the lack of health care insurance coverage and health care access to protect and assure the economic vitality and the health of the state."¹⁵⁰ Texas should not only heed the Task Force's advice and follow California's lead by proposing large health care reforms, but it should go beyond California's proposal and lead the way in protecting the health care rights of all immigrants residing in the state by proposing a system of truly universal health care coverage for all of its residents, as the Task Force suggests, regardless of legal status. Texas is in an even better position than California to propose health care reforms that provide care for immigrants, since the public anti-immigration sentiments or polarizing effects of immigration seen in California during the passage of

143. STATE HEALTH ACCESS DATA ASSISTANCE CTR., CHARACTERISTICS OF THE UNINSURED: A VIEW FROM THE STATES 6 (2005), http://www.rwjf.org/files/research/Full_SHADAC.pdf.

144. *Id.* at 9.

145. *Id.* at 26.

146. STEVEN A. CAMAROTA, CTR. FOR IMMIGRATION STUD., IMMIGRANTS AT MID-DECADE: A SNAPSHOT OF AMERICA'S FOREIGN-BORN POPULATION IN 2005 8 (2005), <http://www.cis.org/articles/2005/back1405.pdf>.

147. TASK FORCE ON ACCESS TO HEALTH CARE IN TEXAS, CODE RED: THE CRITICAL CONDITION OF HEALTH CARE IN TEXAS, THE REPORT (2006), available at <http://www.coderedtexas.org/files/Report.pdf>.

148. *Id.* at 1.

149. *Id.* at 2.

150. *Id.* at 3.

Proposition 187 have not been present in Texas.¹⁵¹ The current health care system that the federal government has provided has failed millions of native-born American citizens as well as immigrants in implementing programs that allow all people to fulfill their human right to health. Texas is uniquely positioned to follow in the footsteps of other states in proposing health care reforms at the local level to meet those needs, and it is also in the state's interest to suggest new solutions that go beyond prior proposals and allow all of its residents to access medical care.

B. EXPANDING ACCESS TO HEALTH CARE IS IN TEXAS'S INTEREST

Texas should propose new reforms to health care policies and support truly universal health care access for all of its residents not only because the evidence shows it is failing in its moral and international responsibilities to provide care and because it is uniquely positioned to propose additional health care access for all immigrants, but also because it is in the state's economic interest to do so. Since chances of an increase in federal health care aid seem slim as Medicare and Medicaid budgets are in danger of being dramatically cut,¹⁵² Texas would be wise to realize the monetary and societal benefits of providing wider access to care for all of its residents. Senator Ray Aguilar of Nebraska exemplifies the attitude that the Texan leadership should embrace, stating that "when there are new populations in your state and you do what you can to help them become productive members of the community . . . you also end up doing everyone else in the community a favor."¹⁵³ Although opponents of providing all immigrants access to health care regardless of legal status note the large costs associated with such care, current health care costs would actually be reduced by providing preventative care to even undocumented immigrants. Because EMTALA and additional state law require hospitals to admit all patients, including undocumented immigrants, for emergency care, it is in the interest of Texas, who is footing the bill for public hospitals, to reduce the cost of that care as much as possible. Costly emergency treatment can be avoided by providing preventative care to ensure that a medical condition is detected at an early stage while it is still treatable and does not rise to the level of a medical emergency, when state money must be used to stabilize a patient.¹⁵⁴ As Governor Schwarzenegger has noted, the cost of treating strep throat is \$72 at a clinic and \$91 in a doctor's office versus \$328 in an emergency room.¹⁵⁵

151. See Gilberto Cárdenas, *Gone to Texas*, DISCOVERY, Feb. 7, 2000, at 29, 32, available at http://www.utexas.edu/opa/pubs/discovery/disc2000v15n3/discovery15_3.pdf; see also Cal. Legis. Serv. Prop. 187 (1994 West).

152. See Robert Pear, *Bush Seeks Big Medicare and Medicaid Saving*, N.Y. TIMES, Feb. 2, 2007, at A15.

153. Boulard, *supra* note 137, at 14.

154. See Neill, *supra* note 8, at 430–32 (discussing economic arguments for providing preventative care, particularly in the form of prenatal care and screening and treatment for chronic and debilitating diseases).

155. George Skelton, *GOP Leaders Offer Governor A Prescription for Expanding Health Coverage*, L.A. TIMES, Feb. 1, 2007, at B3.

Furthermore, providing preventative care also addresses many language barrier issues, as LEPs are more likely to receive care with meaningful physician-patient communication in a preventative care situation when LEPs can intentionally seek out providers who address their needs, rather than being faced with the dangerous language-barrier during a life-death situation once the medical condition has risen to the level of an emergency due to lack of prior care.

Additionally, providing preventative care for undocumented immigrants in the form of prenatal care, immunization for communicable diseases, and screening and treatment for chronic and debilitating diseases is in the interest of the state of Texas. First, Texas should provide prenatal care for all expectant mothers, including all immigrants, regardless of legal status, because it saves the state money and because those mothers' new babies will become United States citizens the moment they are born. Denver, Colorado's public health systems officials calculate that for every \$1 spent on prenatal care for uninsured women, more than \$7 are saved in newborn and child care.¹⁵⁶ The government also saves money when mothers are given prenatal care because the new babies will automatically be United States citizens who must be cared for by the government such that Medicaid benefits will likely be used for these avoidable expenses. Additionally, providing prenatal care will raise the newborn mortality rate in the United States, which has the second highest mortality rate in the industrialized world at five newborn deaths for every 1,000 live births: an unacceptable position for the most powerful and resourceful nation in the world.¹⁵⁷ Second, providing all people, including immigrants, with immunizations for communicable diseases is in Texas's interest because the presence of those diseases in the state negatively affects the entire Texan, and eventually the entire American, population. Because the immigrant population has a high rate of contagious disease infections, such as tuberculosis, immigrants have actually been found to be a significant factor in causing the increase of new cases of tuberculosis in the United States.¹⁵⁸ Anti-immigrant measures that deny undocumented immigrants health care only exacerbate the problem, especially since physicians and health officials believe that lowering the barriers to health care for immigrants is the solution to preventing the spread of contagious diseases and to lowering the high treatment costs that result from treating those diseases.¹⁵⁹ Third, providing screening and treatment to all immigrants for chronic and debilitating diseases, such as diabetes and kidney

156. Erik Eckholm, *To Lower Costs, Hospitals Try Free Basic Care for Uninsured*, N.Y. TIMES, Oct. 25, 2006, at A1.

157. See SAVE THE CHILDREN, STATE OF THE WORLD'S MOTHERS 2006: SAVING THE LIVES OF MOTHERS AND NEWBORNS 37 (2006), available at http://www.savethechildren.org/publications/mothers/2006/SOWM_2006_final.pdf.

158. Shari B. Fallek, Comment, *Health Care for Illegal Aliens: Why It Is A Necessity*, 19 HOUS. J. INT'L L. 951, 969, 972 (1997) (discussing the prevalence of contagious diseases in the immigrant population and its implications and recommending increases in care for illegal immigrants).

159. *Id.* at 976.

disease, makes economic sense for Texas due to the likelihood that these patients will require frequent critical emergency care in the future, which the state is obligated to provide, and which will prove extremely costly. For example, according to Parkland Health and Hospital Center in Dallas, a preventative visit for diabetes costs only \$42, compared with an inpatient hospital stay of \$6,700.¹⁶⁰ Due to the rising number of Hispanic immigrants in Texas, and the higher rates of diabetes among Hispanics, Texas must provide screening and preventative treatment for all immigrants to both save lives that will otherwise be taken by diabetes, one of the leading causes of death in the country, and to save its economic resources to make each dollar go further in medical care.¹⁶¹ State leadership should advance reforms to the current health care system by looking to the recent efforts of local health providers in many Texas cities as well as in local communities all over the country who have already realized the economic and social benefits of responding to immigrants' health care needs by providing preventative and meaningful care.

C. LOCAL HEALTH CARE PROVIDERS HAVE RECOGNIZED THE
BENEFITS OF PROVIDING PREVENTATIVE CARE

Local hospitals throughout Texas have already begun recognizing the importance of preventative care and have initiated their own programs to help the uninsured. For example, at Parkland Memorial Hospital in Dallas, which births the second largest number of infants in the country,¹⁶² a patient survey revealed that 70% of the women who gave birth at the hospital in the first three months of 2006 were undocumented immigrants, but Dr. Ron Anderson, Parkland's president and chief executive officer notes that Parkland was historically "tasked with taking care of the indigent sick of Dallas County . . . that included the immigrant population, both legal and illegal."¹⁶³ Dr. Anderson believes that "[d]octors and nurses are in the healing business and not the immigration business . . . You're left with a human being in front of you who's going to deliver a baby and who needs your help."¹⁶⁴ The staff at Parkland seeks to take care of all of its Dallas county residents, regardless of immigration status, and although they ask for identification documents, they do not ask for proof of legal status, but rather assure their patients that none of their

160. CHILDREN'S DEFENSE FUND, CHIP: SAVING TEXANS MONEY, KEEPING FAMILIES FIRST 1 (2006), <http://www.cdf-texas.org/attached/CHIPCostSavings.pdf>.

161. See NATIONAL DIABETES EDUCATION PROGRAM, THE DIABETES EPIDEMIC AMONG HISPANIC AND LATINO AMERICANS FACT SHEET 1 (2005), http://www.ndep.nih.gov/diabetes/pubs/FS_HispLatino_Eng.pdf.

162. Sherry Jacobson, *Parkland Brimming with Babies*, DALLAS MORNING NEWS, June 11, 2006, available at <http://www.dallasnews.com/sharedcontent/dws/news/localnews/stories/061106dnmetbabyfactory.8539095.html>.

163. Sherry Jacobson, *Parkland Will Treat All Moms-To-Be*, DALLAS MORNING NEWS, June 12, 2006, available at <http://www.dallasnews.com/sharedcontent/dws/news/localnews/stories/061206dnmetmoms.d9b9669.html>.

164. *Id.*

documents will be shared with immigration officials.¹⁶⁵ The hospital has gone beyond merely fulfilling its EMTALA obligations of admitting all women in labor regardless of legal status by providing prenatal care at the hospital's clinics throughout low income areas in Dallas, which are used by more than 90% of the women who deliver at Parkland.¹⁶⁶ The prenatal care given to all expectant mothers improves the chances of birthing a healthy baby, which translates into lower costs for the hospital, since for every dollar spent on prenatal care, several more are saved on delivery and postpartum care for underweight babies at birth or related complications.¹⁶⁷ "The Parkland Way," as the Hospital proudly calls its system, also produces impressive results with far lower neonatal and newborn mortality rates than the Texas or national averages.¹⁶⁸ Dr. Anderson also believes that preventative care makes sense for conditions outside of delivery care as well and states that, "from a good public health policy perspective, we would provide preventative care so as to avoid the higher costs of emergency care and hospitalization, which we would be forced to provide."¹⁶⁹ Texas should look to Parkland's special efforts to maintain community clinics, provide prenatal and wider preventative care to all its residents in need, and provide a high standard of emergency care regardless of its patients' ethnic or legal statuses as evidence of what a human right to health could look like. Additionally, Texas lawmakers should do their part to assure that all of its residents have this right.

Surprisingly, apart from the efforts of Parkland and other community hospitals around the state to provide preventive care for all people, private hospitals in Texas that do not share the position or obligations of public hospitals have also begun to offer preventative care out of self-interest. These hospitals, which are also obligated to provide emergency care under EMTALA, are providing preventive care because they have realized that non-emergency medical care not only saves the health of the patient, but also saves the hospital significant amounts of money. The Seton Family of Hospitals in Austin is a Catholic hospital network that manages seven hospitals in the area, including the oldest public hospital in Texas and the city's community hospital, Brackenridge, under a historic agreement with the City of Austin.¹⁷⁰ The network also includes three primary care clinics for the uninsured which use a sliding-scale fee system.¹⁷¹ Dr. Melissa Smith, the medical director of Seton's community health clinics, explains how the network's preventative care system bene-

165. *Id.*

166. Jacobson, *supra* note 162.

167. *Id.*

168. *Id.*

169. Neill, *supra* note 8, at 430-31.

170. Seton Family of Hospitals, About Seton, http://www.seton.net/about_seton/ (last visited Sept. 18, 2007).

171. Seton Family of Hospitals, About Seton: Charity Care, http://www.seton.net/about_seton/charity_care/ (last visited Sept. 17, 2007).

fits both the 5,000 working poor¹⁷² individuals they serve and the organization's bottom line because the patients "can have better care and we can reduce the costs for the hospital."¹⁷³ The case of Dee Dee Dodd, an insulin-dependent diabetic woman who cannot afford health insurance, shows these mutual benefits: she went from being rushed to the emergency room on a monthly basis for intensive care treatment which cost Seton \$191,277 over an eighteen-month period, to much better health and medical bills that have been cut in half after getting primary care from Seton. As Dr. Smith explains, "[t]he money we save . . . money that is not hemorrhaging through the I.C.U., is money we can do so much more with to help her upfront."¹⁷⁴ Seton and other private hospitals are thus bringing in the uninsured, particularly those with chronic conditions such as diabetes, hypertension, congestive heart failure, and asthma, even reaching out to those who live outside of the county of the hospital's prescribed charity plan, in order to provide free preventative care because that will prove much less expensive than the high costs of multiple emergencies for those same individuals.¹⁷⁵ The evidence is so clear that providing screening for debilitating diseases and preventative care makes sense for all uninsured people who will otherwise end up harming themselves and the hospital with dangerous and costly emergencies, that even some progressive private hospitals are already implementing changes that the Texas lawmakers should prescribe.

D. IMPROVING ACCESS TO MEANINGFUL CARE: CULTURE AND
LANGUAGE TRAINING REQUIREMENTS IN TEXAS HEALTH
CARE PROGRAMS

In order to protect the human right to health all people in the United States possess, Texas should also lead the states in advancing reforms that not only increase physical access to medical care, but that also address the hurdles immigrants face in accessing meaningful care, such as language and cultural barriers, given its position as the state with the highest number of uninsured residents and the second highest increase in immigration. Since the best way to address such deeply seeded issues as discrimination is through educational efforts, Texas should look to the efforts its educational institutions are already making to increase cultural sensitivity and Spanish language training among future Texas health care providers. The realization that cultural and language differences between patients and their health care providers lead to patient dissatisfaction, low adherence to treatment, and poor outcomes in patient health produced a

172. The U.S. Department of Labor defines the "working poor" as people who spent at least 27 weeks in the labor force, but whose incomes fell below the official poverty threshold. U.S. BUREAU OF LABOR STATISTICS, A PROFILE OF THE WORKING POOR, 2003 1 (2005), <http://www.bls.gov/cps/cpswp2003.pdf>. These people thus often do not qualify for Medicaid, but also cannot afford health insurance.

173. Eckholm, *supra* note 156, at A1.

174. *Id.*

175. *Id.*

movement among the medical community of providing “cross-cultural care” for all people many years ago.¹⁷⁶ This movement “evolved from the making of assumptions about patients on the basis of their background to the implementation of the principles of patient-centered care, including exploration, empathy, and responsiveness to patients’ needs, values, and preferences,” and although it will not “single-handedly improve health outcomes and eliminate disparities,” it is a “necessary set of skills for physicians who wish to deliver high-quality care to all patients.”¹⁷⁷ The push for cross-cultural care has been advanced by the American Medical Association, which created the Federation Task Force on Disparities in Health Care in 2002 to address the cultural competence of physicians, among other issues affecting racial and ethnic disparities in health care.¹⁷⁸ Even though the medical community has recognized the importance of all patients receiving meaningful care, a study published in the *Journal of the American Medical Association* showed the need for “significant improvement in cross-cultural education to help eliminate racial and ethnic disparities in health care,” as it found that although nearly all resident physicians believe it is important to consider a patient’s culture when providing care, twenty-five percent said that they were not prepared to treat new immigrants, twenty-four percent said they could not identify relevant cultural customs that impact medical care, and half reported receiving little or no training in understanding how to address patients from different cultures.¹⁷⁹ This study highlights the need for education in cultural competency in order to provide every person the level of meaningful health care prescribed by the American Medical Association, the medical community at large, and international standards.

Several of the top health care programs in Texas are setting high examples for other schools to follow by seeking to provide this education to their health sciences students. For example, the University of Texas Southwestern Medical Center’s Allied Health Sciences School at Dallas has instituted a required multi-semester, linguist-taught medical Spanish curriculum for its physician assistant students in order to enhance patient care.¹⁸⁰ The program, in which the students meet for two hours a week for three semesters, combines both educational and practical elements to ensure their future patients receive meaningful care.¹⁸¹ In the first semester, students learn Spanish grammar and medical vocabulary; the sec-

176. Joel S. Weissman et. al., *Resident Physicians’ Preparedness to Provide Cross-Cultural Care*, 294 J. AM. MED. ASS’N 1058, 1058 (2005).

177. Joseph R. Betancourt, *Becoming a Physician: Cultural Competence—Marginal or Mainstream Movement?*, 351 NEW ENG. J. MED. 953, 953 (2004).

178. THE COMMISSION TO END HEALTH CARE DISPARITIES, 2005 SUMMARY 7–8 (2005), available at <http://www.ama-assn.org/ama1/pub/upload/mm/433/summary05.pdf>.

179. Weissman et. al., *supra* note 176, at 1061–62, 1066.

180. Press Release, The University of Texas Southwestern Medical Center at Dallas, Unique ‘Medical Spanish’ Course Helps Physicians Assistants Better Examine, Communicate with Hispanic Patients (July 5, 2006), <http://www.utsouthwestern.edu/utsw/cda/dept37389/files/302340.html>.

181. *See id.*

ond semester includes mock physical exams with trained, Spanish-speaking simulated patients in a clinical setting; and the third semester requires students to give a presentation on an illness in Spanish and conduct mock physical exams on each other.¹⁸² Former graduates of the program have valued the program's effect on their practice and found that it has made "[p]atients feel comfortable in sharing their symptoms, and [allowed graduates to] better educate them about their health condition."¹⁸³ The University of Texas at Austin has also instituted a required medical Spanish course for its nursing students, so that students should graduate being able to prescribe medication in Spanish, guide patients through basic procedures such as drawing blood, and are able to communicate about body parts and basic body functions in Spanish.¹⁸⁴ Outside of the state, the fourth-year medical students at Wake Forest Medical School elected to make a five-week Spanish course a training requirement for their program.¹⁸⁵ The Texas Medical Board should institute a similar requirement among medical schools in Texas, as should every nursing and allied health program in the state, in order to provide meaningful health care for all of Texas's residents and bring every person closer to receiving the level of health that international standards prescribe.

The University of Texas Medical Branch (UTMB) in Galveston is an emblematic example of organic efforts grown out of a need for improving access to meaningful health care. The school provides several medical Spanish and Hispanic culture courses for some of its first year students, as well as an elective in the third or fourth year.¹⁸⁶ But what makes UTMB's program unique is a service organization founded and staffed by the medical, nursing, and allied health students of the school as part of its Institute for the Medical Humanities called *Frontera de Salud*.¹⁸⁷ This program improves access to meaningful health care both in the present and the future, as it provides primary health care to the underserved while furthering health care students' clinical skills, as well as competency in Spanish language and cross-cultural care. As part of the program, every six to eight weeks, around thirty culturally diverse medical, nursing, and allied health students from UTMB Galveston and the University of Texas Health Science Center at San Antonio spend a weekend in Brownsville, Corpus Christi, or Laredo, caring for patients in those underserved communities by performing well-woman exams, health screen-

182. *Id.*

183. *Id.*

184. Lydia Lum, *Speaking the Patient's Language*, BLACK ISSUES IN HIGHER EDUCATION, Sept. 26, 2002, at 28, 29.

185. Myrle Croasdale, *Students Request Results in Course in Medical Spanish*, AM. MEDICAL NEWS, June 24, 2002, available at <http://www.ama-assn.org/amednews/2002/06/24/prsc0624.htm>.

186. Interview with Dr. Kirk Smith, Executive Director, *Frontera de Salud*, Univ. of Tex. Med. Branch (Feb. 11, 2007).

187. See The Institute for the Medical Humanities: *Frontera de Salud*: Program Summary, <http://www.utmb.edu/imh/Frontera.asp> (last visited Oct. 16, 2007).

ings at the community church, and making house calls.¹⁸⁸ In addition, an Integrated Community Health Elective is available for about five senior medical residents a year, in which these residents live in a *colonia* on the border for a month providing clinic care, supervising the visiting *Frontera* students, and helping to build new modules to support long-term community care.¹⁸⁹ As Dr. Kirk Smith, the executive director of the *Frontera* program, describes, the program not only benefits the community by providing much needed health care, but also the students who participate in the program by familiarizing them with the actual state of the health care system and providing hands-on training on how to promote community based health.¹⁹⁰ Dr. Smith notes that “with the traditional hospital and clinic based model, [students] are only seeing a part of the picture and can be misled about the gravity of the situation of people without access to care. [In the *Frontera* program] we’re teaching them how to do preventative care and to work within the current system.”¹⁹¹ In UTMB’s program, the community-oriented primary care model demonstrated by Dallas’ Parkland Hospital is brought to a whole other level by combining it with language and cultural competency training and providing lasting impacts on a new generation of health care professionals who learn to deal with the barriers to meaningful access to health care. As this program shows, Texas is uniquely positioned and ready to lead the way in protecting every person’s right to health by increasing physical and meaningful access to care for all.

CONCLUSION

The international community set a high standard over fifty years ago by requiring every signatory of the International Covenant on Economic, Social, and Cultural Rights to respect and implement efforts to secure every human’s right to health. At that time, the United States agreed to uphold that ideal and Franklin Roosevelt encouraged the nation to accept the idea that everyone deserves a protected right to adequate medical care and good health. However, the federal government has not kept its promises when, decades later, the human right to health is not protected in America, as can be seen by the huge number of uninsured citizens, particularly when one examines the barriers that immigrants face in physical and meaningful access to care and the low levels of health care these individuals receive. At a time when the number of immigrants from poorer nations is increasing, the inadequate results of the faulty health

188. Interview with Dr. Kirk Smith, Executive Director, *Frontera de Salud*, Univ. of Tex. Med. Branch (Feb. 11, 2007); UTMB frontera de salud: About, <http://www.utmb.edu/frontera/about.asp> (last visited Oct. 16, 2007).

189. Interview with Dr. Kirk Smith, Executive Director, *Frontera de Salud*, Univ. of Tex. Med. Branch (Feb. 11, 2007); UTMB frontera de salud: Physicians, <http://www.utmb.edu/frontera/physicians.asp> (last visited Oct. 16, 2007).

190. Interview with Dr. Kirk Smith, Executive Director, *Frontera de Salud*, Univ. of Tex. Med. Branch (Feb. 11, 2007).

191. *Id.*

care system show that the nation with the largest resources in the world is not meeting international standards and that something must be done to prevent more people from being deprived of their right to health.

Since local communities are feeling the effects in lost lives and a lower quality of life for millions of people, some states are advancing reforms that at least hope to provide care for more of their residents. Texas must join these states in order to both improve the lives of millions of uninsured people—a number that will continue to rise with immigration—and to save itself economically and benefit all of its citizens. The current efforts of the state's public and private hospitals to increase physical access to care, as well as those of the educational health care institutions to provide meaningful care, prove that the medical community has already acknowledged the health rights of all people and that they must be supported by the state's public figures. Texas can provide these local solutions to ensure that the American promise to respect every human's international right to health will be respected in the state, and can provide leadership so that the right to health can become a reality for all people in the United States and internationally.